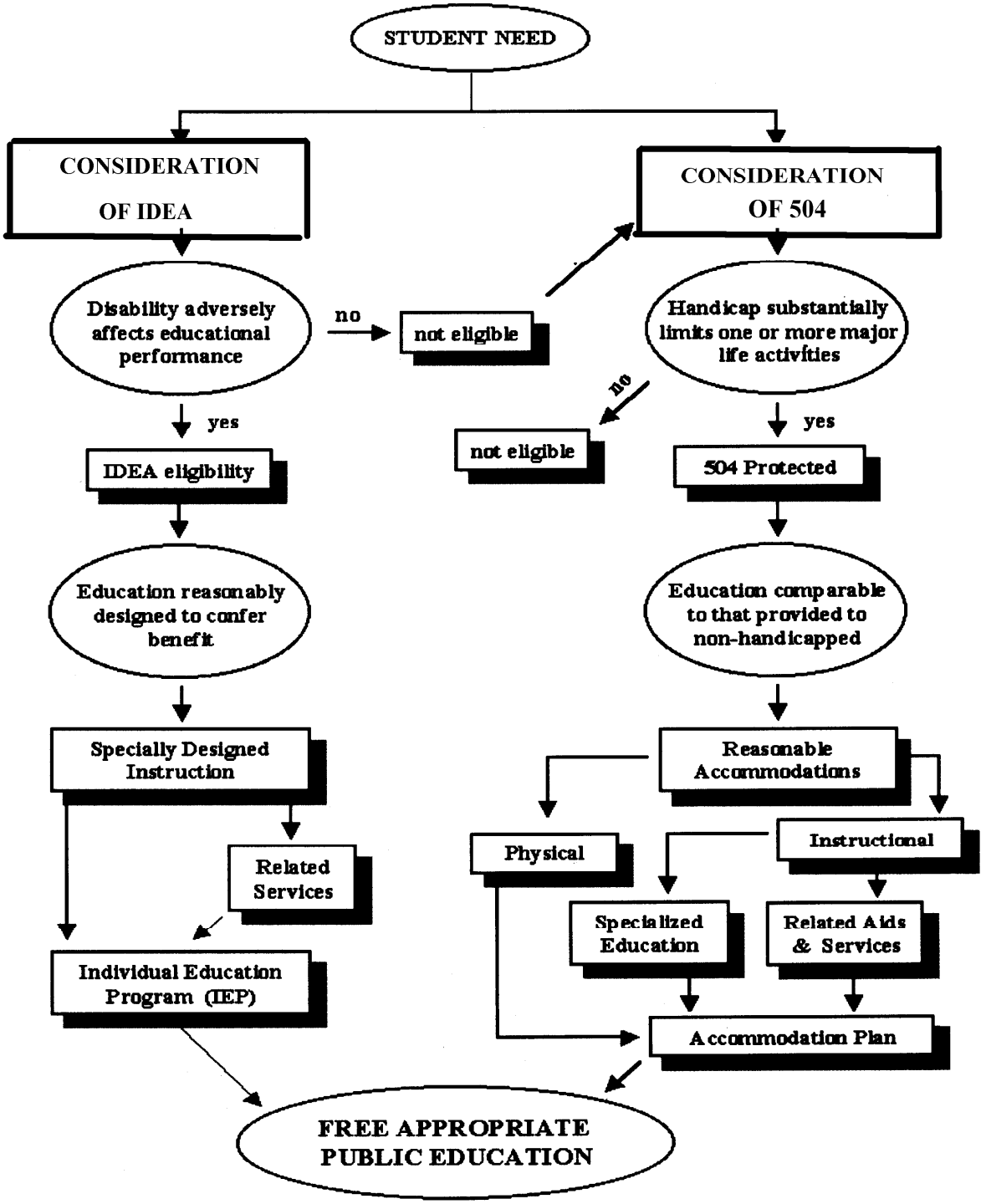
IDEA /504 FLOWCHART



Source: Zaiger, NASN, School Nursing Practice, An Orientation Manual, Chapter IX, pg. 23

Glossary of IDEA terms

"Free appropriate public education or FAPE" means special education and related services that (a) are provided at public expense, under public supervision and direction, and without charge; (b) meet the standards of the SEA, including the requirements of this part: (c) include preschool, elementary school, or secondary school education in the State; and (d) are are provided in conformity with an individualized education program (IEP) that meets requirements in the federal regulations.

"Least restrictive environment" is concept that requires each public agency to ensure (1) That to the maximum extent appropriate. Children with disabilities, including children who are nondisabled; and (2) That special classes, separate schooling or other removal of children with disabilities from the regular educational environment occurs only if the nature or severity of the disability is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily. Each public agency must ensure that a continuum of alternative placements is available to meet the needs of children with disabilities for special education and related services. The continuum required must (1) include the alternative placements listed in the definition of special education including instruction in hospitals and institutions; and (2) make provision for supplementary services (such as resource room or itinerant instruction) to be provided in conjunction with regular class placement (Source: 34 CFR 300.550-551)

Related services is defined in IDEA as transportation and such developmental, corrective and other supportive services as are required to assist a child with a disability to benefit from special education, and includes speech-language pathology and audiology services, psychological services, physical and occupational therapy, recreation, including early identification and assessment of disabilities in children, counseling services, including rehabilitation counseling, orientation and mobility services, and medical services for diagnostic or evaluation purposes. The term also includes school health services, social work services in schools, and parent counseling and training.

- **Audiology** includes (i) Identification of children with hearing loss; (ii) Determination of the range, nature, and degree of hearing loss, including referral for medical or other professional attention for the habilitation of hearing; (iii) Provision of habilitative activities, such as language hablitiation, auditory training, speech reading (lip reading), hearing evaluation, and speech conservation; (iv) Creation and administration of programs for prevention of hearing loss; (v) Counseling and guidance of children, parents, and teachers regarding hearing loss, and (vi) Determination of children's needs for group and individual amplification, selecting and fitting an appropriate aid, and evaluating the effectiveness of amplification.
- **Rehabilitation counseling services** means services provided by qualified personnel in individual or group sessions that focus specifically on career development, employment preparation, achieving independence, and integration in the workplace and community of a student with a disability. The term also includes vocational rehabilitation services provided to a student with disabilities by vocation rehabilitation programs funded under the Rehabilitation Act of 1973, as amended.

- **School health services** means the provision of direct health care, including the administration of medication, the operation, maintenance of health care through the use of medical equipment; or the administration of clinical procedures provided by a health care professional. Health care services does not include first aid or emergency procedures. Health services shall be provided within the health care professionals current scope of practice.
- **Social work services in schools** includes (i) Preparing a social or developmental history on a child with a disability; (ii) Group or individual counseling with the child and family; (iii) Working in partnership with parents and others on those problems in a child's living situation (home, school and community) that affect the child's adjustment in school; (iv) Mobilizing school and community resources program; and (v) Assisting in developing positive behavioral intervention strategies.
- **Speech-language pathology services** includes (i) Identification of children with speech or language impairments; (ii) Diagnosis and appraisal or specific speech or language impairments; (iii) Referral for medical or other impairments; (iv) Provision of speech and language services for the habilitation or prevention of communicative impairments; and (v) Counseling and guidance of parents, children, and teachers regarding speech and language impairments.
- **Transportation** includes (i) Travel to and from school and between schools; (ii) Travel in and around school buildings; and (iii) Specialized equipment (such as special or adapted buses, lifts, and ramps) if required to provide special transportation for a child with a disability. (Source CRF 300.24)

Glossary of Section 504 terms

"Major life activities" means functions such as caring for one's self, performing manual tasks such as walking, seeing, hearing, speaking, breathing, learning, and working.

"Has a record of such an impairment" means has a history of, or has been misclassified as having, a mental or physical impairment that substantially limits one or more major life activities.

"Is regarded as having an impairment" means (A) has a physical or mental impairment that does not substantially limit major life activities but that is treated by a recipient as constituting such a limitation; (B) has a physical or mental impairment that substantially limits major life activities only as a result of the attitudes of others toward such impairment; or (C) has none of the impairments defined in this section but is treated by a recipient of federal funds as having such an impairment. (Source CRF 84.3)

Glossary of Kentucky Terms
These terms may be found in KRS 157.200 at the following web site:
http://www.lrc.state.ky.us/krs/157-00/200.pdf

CRITERIA FOR SELECTION OF HEALTH PROBLEMS TO BE INCLUDED IN THE HEALTH COMPONENT OF THE INDIVIDUAL EDUCATIONAL PLAN

Does the child have a health condition which will:

- Require teacher training and supervision for the performance of specialized treatments and procedures?
- Require special counseling for school adjustment, not only personally but also for classmates?
- Require change outside of the classroom, e.g. removal of architectural barriers?
- Require changes inside the classroom, e.g. special lighting, new desks?
- Require special safety precautions (on buses, playground, gym, etc.)?
- Result in limited energy stores or pain or discomfort, thereby giving diminishing productivity?
- Require a special diet, or supplemental feeding?
- Require special assistance with activities of daily living (e.g. dressing, toileting, feeding)?
- Require administration and storage of medications at school?
- Require regular contact between the school and the physician?
- Require adaptation of school health program?
- Require the maintenance of special equipment, records, etc.?

Source: Zaiger, D.S. NASN School Nursing Practice, An Orientation Manual, Ch. IX

GUIDELINES FOR HEALTH CARE PLAN FOR STUDENTS WITH SPECIAL HEALTH CARE NEEDS

I. Purpose

Enrollment of students with special health care needs in the school setting presents a challenge to students, families, and school staff. Development of a health care plan provides for effective and efficient delivery of services that promotes school success for the student and reduces the liability of the school district.

II. Responsibilities

A. Parent/Guardian

The parent/guardian has the most information regarding the unique needs of the child and should play a major role in the development of the health care plan. This role includes:

1. Being an advocate for their child.
2. Providing access to health care providers for information and orders for the medications and treatments necessary.
3. Participating in the identification and training of providers in the school setting for child-specific procedures.
4. Approval of the health care and emergency plans.
5. Notifying the school nurse of changes in the student's condition, health care providers, or health care needs.

B. Administrator

1. Reviews the appropriate health and education assessments to determine the needs of the student in the school setting.
2. Provides adequate staffing to address the student's educational, transportation, and health needs.
3. Provides time and support for training of registered nurses and other staff as deemed necessary.
4. Informs the Director of Transportation of the student's needs for health care. Provides a copy of the Emergency Action Plan and arranges needed in-service training.
5. Manages potential environmental concerns such as:
   a) informing all personnel (e.g., lunchroom, playground staff) of potential situations
   b) special equipment needs (e.g., wheelchair ramp, bathroom adaptations, etc.)
   c) extermination of insects to safeguard students from possible insect bites and stings
   d) emergency power supply for life sustaining equipment
   e) appropriate outlets for health care equipment, etc.
6. Knows the potential for available emergency medical services:
   a) local emergency unit–level of training
   b) what medications available, trained to give
   c) how long does it take to get there
   d) cost of transportation
   e) flight rescue availability–cost, time from hospital
7. Communicates with parent:
   a) developed plan and potential concerns
   b) expected costs and who will be responsible

Source: Zaiger, D.S. (2000) School Nursing Practice, An Orientation Manual, Chapter IX, pg. 31-35

c) ensures that parents have supplied necessary emergency information

C. School Nurse
   1. Reviews emergency and/or health information and determines which students will require a written health care plan.
   2. Obtains significant health data on identified students.
   3. Completes a nursing assessment and summarizes data on Significant Health Information sheet (see sample form). This data base should include:
      a) age of student at onset of condition
      b) description of condition/course of illness
      c) summary of treatment
      d) other significant illnesses, allergies
      e) date last seen by primary health care provider for noted condition
      f) name, address, and phone numbers for care provider
      g) significant emergency information (see sample form)
      h) preferred hospital
      i) what constitutes a medical emergency for this student
      j) orders, supplies, or medications needed for medical emergency
      k) health care procedures, including administration of medication, and equipment and who will be responsible for obtaining
   4. Secures permission for release of confidential information for all sources of significant medical information.
   5. Develops and implements the health care plan to be carried out at school (see sample form). This plan should include situations that might arise while student is on bus, on field trips, during safety drills, and in the event of a disaster. The plan should include the following components:
      a) student identification data and date of plan
      b) description of the health condition and possible effects on this student. If multiple health conditions exist, each should be listed as a separate problem
         1) general guidelines for determining action
         2) procedures
            (i) medication and equipment needs and storage requirements
            (ii) possible adverse effects of medications or procedures
            (iii) signed orders if applicable
            (iv) parent authorizations
            (v) names and phone numbers of important personnel
            (vi) documentation of training personnel
      c) identifies school personnel to be trained in child-specific procedures and problem management
      d) ensures that plan is typed and signed by parent, nurse, and administrator. Obtains health care provider's signature if prescribed health care is to be provided at school.
   6. Files health care plan in student's record and notes on emergency card that a health care plan is on file; makes IHP available to substitute staff.
   7. Ensures that a child-specific emergency plan is developed in collaboration with school administration, community emergency personnel, and family; and is available to those who might need it.
   8. Sees that the medication and/or treatment procedures are performed and documented.

9. Provides general staff training to give an overview of the student's condition and health care needs. This overview should be done in collaboration with the parents and the child's health care providers. Personnel who should attend this general training might include teachers, administrator and/or special education director, community emergency personnel, and other staff who will be in contact with the student, such as the bus driver, lunchroom and playground staff, occupational and physical therapists. Topics that should be covered include:
    a) overview of student's condition and special health care needs
    b) detailed review of student's health care plan
    c) overview of anatomy and physiology when appropriate
    d) roles and responsibilities of school personnel in the daily and emergency care of the student at school
    e) transportation issues and personnel involved
    f) emergency plan and procedures
10. Communicates with parents.

D. Staff members should be encouraged to ask questions during training sessions and be assured that they will be updated with any changes in the student's condition or placement.

E. Health Care Provider
    1. Serves as a team member in developing a health care plan which is functional in this school setting.
    2. Identifies health information and services which must be provided in the school setting (cannot be provided outside school hours).
    3. Writes prescription for parent to obtain medication and/or equipment needed.

Medications	**Equipment**
dosage	purpose
route of administration	directions for use
Site of injection	precautions
Side effects to note	other
other	

    4. Provides orders for medications and procedures that must be provided in school.

Adapted from: Missouri Department of Elementary & Secondary Education & Missouri Department of Health (1990). Guidelines for special health care procedures in Missouri schools.

Guidelines for Development of Individualized Health Care Plan (IHP)

Personal Data

Name
Sex
Age or date of birth
Grade or teacher's name
Medical diagnosis
Physician's name and phone
Parent/guardian's name and phone

Nursing Process

Assessment

Health History—general health, medical care, development, relevant family history, conditions, or life styles.
Present Health Status—subjective and objective data related to functional health patterns.
Note patterns of health perception/health management, nutrition, elimination, activity, cognition, self-perception, role-relationships, sexuality, coping/stress tolerance, and values/beliefs.
(It is helpful to use a standardized form to gather the history and information about current status.)

Nursing Diagnosis or Problem Statement

The etiological factors, signs and symptoms, and other information collected in the assessment phase need to be organized and summarized into a statement of the student's problem or need.

Plan of Care

Goals
Usually broad statements of the overall desired outcome.
May be written in terms of goals of the student or may be written as goals of nursing intervention.

Nursing Interventions

Describe actions of the nurse to provide appropriate nursing services to the student in the school setting based on the diagnosis derived from the assessment.
May include screening and referral, treatment or medications, health maintenance activities, and client, family, or staff education.

Expected Client Outcomes

Outcomes describing how the student's problem or need will be different (hopefully healthier) as a result of the nursing interventions.
Client (student) outcomes may be long or short term. The expected outcomes provide the "evaluation" of the nursing process.

References: Haas, M.B et. al. (1993). *The school nurse's source book of individualized healthcare plans.* Vol. I.

Source: Zaiger, D.S. (2000) School Nursing Practice, An Orientation Manual, Chapter IX, pg. 31-35

HEALTH SERVICES
INDIVIDUALIZED HEALTH CARE PLAN (IHP)

Student Name:	Age:	Medical Diagnosis:

Health History:	Current Information and Assessment:

Prepared by:	Date:	Reviewed by:	Date:	Reviewed by:	Date:

Goals:

Nursing Diagnosis and/or Student Problem	Interventions	Outcome/Evaluation

Source: Zaiger, D.S. (2000) School Nursing Practice, An Orientation Manual, Chapter IX, pg. 31-35

Individual Educational Plan (IEP)

Content of the Individualized Education Program

The individualized education program, as mandated by IDEA, for each child must include:

1. A statement of the child's present levels of educational performance.
2. A statement of annual goals.
3. A statement of short-term instructional objectives.
4. A statement of specific education and related services to be provided to the child.
5. A description of the extent to which the child will participate in regular educational programs and a description of the program to be provided.
6. The projected dates for initiation of services and the anticipated duration of services.
7. Objective criteria, evaluation procedures, and a schedule for determining, on at least an annual basis, achievement of the short-term instructional objectives.

IEP Development

The annual goals and short-term instructional objectives components of the IEP document are discussed in the following sections. Health concerns to be addressed within the student's special education program are included in the short-term objectives section.

Annual Goals

A goal is a broad, general statement representing the anticipated achievement of a student within one school year.

Example:

Given consistent and continuous guidance from the health service provider, James will assume responsibility for taking his own medication.

Short-Term Objectives

These are specific, concise statements that reflect the intermediate steps required to accomplish the goal. The objectives must be measurable and say what the student will be able to do.

The components of a behavioral objective are:

- Who is to **perform** it?
- What is the specific **observable behavior** (or act) that the student is to perform?
- What is the **product, performance,** or **result** of the student's behavior?
- What are the **relevant conditions** under which the behavior is to be performed?
- What is the **standard for evaluation,** the minimum level of acceptable performance?

Examples:

James will accurately state the time(s) of day his medication is to be taken by November 30.
James will list six side effects of his medication with 100 percent accuracy by March 1.

When writing the behavioral objectives, there are some major points to remember:

- Pinpoint exact skill levels,
- Translate skill level into objectives,
- Determine intermediate steps from least complex to most complex,
- Determine sequences of skills to make sure each learning step is small enough to ensure success,
- Modify as necessary,
- Establish a behavior modification program to reward the student for achievements, no matter how small they are.

The following information is from the Kentucky Systems Change Project, Services for Students with Special Health Care Needs, Appendix C, pp. 80-84.[11]

DEVELOPING APPROPRIATE INDIVIDUAL EDUCATION PROGRAMS FOR STUDENTS WITH SPECIAL HEALTH CARE NEEDS

Historically, Individual Education Programs, (IEP's) for students with complex health care needs have often contained objectives that indicated what would be done to the student and not what the student will learn. For example, the IEP may have contained **Inappropriate or noninstructional objectives** such as:

"The student will be fed three times a day with a gastro-intestinal feeding tube" or " The student will be positioned in 5 different positions throughout the school day."

Objectives such as these can be referred to as "staff directives" as opposed to student objectives. The content of "objectives" such as these refers to related services the students require during the school day. As with other related services, such as physical therapy, procedures requiring support from school health services are included in the student's IEP. The IEP also contains information about how often the related service will be provided. With related services such as physical therapy, the skills the physical therapist wants included in the IEP will be written on the ARC Summary. However, when the related service is a school health service, the process is somewhat different in that the health procedures are not in and of themselves skills the student will learn.

Thus, it is suggested that teachers include information about health care procedures on a separate page of the IEP. Information that is provided on this page includes (a) a description of the required procedures, (b) the person who is primarily responsible for carrying out the procedures, (c) the back-up person(s) who will carry out the procedures in the absence of the primary person, and (d) when the procedures will be initiated, reviewed and end. An example of how this might look is shown below:

Required Procedure	**Responsible Person(s)**	**Date**	
Date		**Begin**	**End**
The student will receive medication three times per day each day he/she is at school.	Teacher (Primary) Teacher Assistant (back-up)	08/03	06/04

Once the procedure has been included in the IEP, a program plan is developed for each procedure. The plan includes the student's name, name and description of procedure, the primary and back-up person(s) responsible for carrying out the required to perform the procedure as outlined by a qualified medical personnel (e.g. physician, nurse), materials needed to perform the procedure and documentation required.

The teacher will also write instructional objectives related to instruction that will occur during the health care routine. Health care procedures are routines that are required on a daily basis. They are not skills for the student to learn. However, health care routines may take a significant portion of the student's day, and are viewed as opportunities for instruction as would be any other activity. Health care routines can be utilized for instruction by embedding instruction in basic skills (e.g. communication, motor, sensory) into these routines. An objective which includes the health care procedure of gastro-intestinal feeding might look like this:

> When involved in an activity (described below) and given a verbal cue to "reach for _____" and when the item is placed 2-4" in front of the student, he will extend his right forearm from the elbow to make contact with the item within 15 seconds, 4 of 5 opportunities (for 3 consecutive days).
>
> Examples of activities in which the student will practice reaching are:
> 1. reaching for switch to operate appliance during snack
> 2. reaching for switch to operate video game during leisure time
> 3. reaching for coat hook to hang up coat during arrival time
> 4. reaching for switch to operate electric can opener to open can of formula for G-tube feeding
> 5. reaching for he supplies during G-tube feeding to assist with feeding during lunch

The health care routine can then be added to the activity matrix as an activity occurring during the student's daily schedule.

Although, usually health care procedures are not in and of themselves instructional objectives for the child, there may be one exception. For certain procedures, it is possible, that some students might eventually perform them independently. Self-catheterization is one example. Students with adequate cognitive and physical abilities can be taught to catheterize themselves, and are encouraged to do so. With procedures such as these, instructional objectives are written to reflect independence as the criterion. An example is shown below:

> "When given the materials needed for self-catheterization and given the verbal command to do so, the student will catheterize himself by independently performing 100% of the steps of catheterization 2 of 2 times per day of the school year."

Self catheterization falls within the independent living domain and certainly would be considered a functional skill to teach. For programming planning purposes, the teacher develops a task analysis of the steps required to perform catheterization and identifies an appropriate instructional strategy for teaching the procedure. Making both of these decisions requires input from the student's physician or school nurse.

As with other related services, health care procedures need to be addressed on the IEP. Teachers and other members of the Admissions and Release Committee (ARC) should remember the following when including these procedures:

1. If the procedure has to be performed by an adult, it should not be included as an instructional objective for the child.

2. Administering health care procedures is considered a related service and is included on the IEP, but not written as an instructional objective.
3. Health care procedures are considered routines in which instruction can occur. Basic skills taught within these routines are included on the IEP noting that the routine provides an additional context for instruction of these skills.
4. Some students may be able to independently perform certain health care procedures themselves. Systematic instruction is planned with input from appropriate medical personnel.(ref #11)

SAMPLE SECTION 504 PLAN AND HEALTH CARE PLAN FOR A STUDENT WITH DIABETES

Attached is a sample Section 504 Plan and Health Care Plan detailing typical medical and academic needs of a child with diabetes at school. The Plan outlines the responsibilities of the student, parents/guardians, and the school. The Health Care Plan sets out the student's specific medical needs as determined by his/her health care team. Ideally, these documents are developed as a result of a cooperative effort involving the family, the child's health care team, and the school/school district.

The terms "Section 504 Plan" or simply "504 Plan" refer to a plan developed to meet the requirements of a federal law that prohibits discrimination against people with disabilities, Section 504 of the Rehabilitation Act of 1973, commonly referred to as "Section 504." Section 504 applies to all public schools and to private schools that receive federal funds. This sample plan would also be appropriate under another law that protects students with disabilities, the Americans with Disabilities Act. The Americans with Disabilities Act covers all public schools and all private schools except those run by religious entities. Although such plans are typically referred to as "Section 504 Plans," your school may use a different name.

If your child has qualified for services under the Individuals with Disabilities in Education Act, also known as "IDEA," your child's school plan may be called an "Individualized Education Plan" or "IEP." Typically, an IEP is more specific than a 504 Plan with regard to the student's academic needs.

It is important to keep in mind that the attached 504 Plan is only a sample plan listing those things typically needed by children with diabetes in schools. The sample plan must be adapted to the individual needs, abilities, and medical condition of your child. Not all of the accommodations listed are needed for every child with diabetes. You should include those items in the sample that are needed for your child. Talk to your medical team about what plan makes sense for your child.

The attached 504 Plan envisions a child with type 1 diabetes who takes insulin by injection. Therefore, the plan would have to be modified for a child with type 2 diabetes, especially a child who does not take insulin, or for a child who is on an insulin pump. In addition, your state or school district may have its own standards for training those staff members who provide diabetes care to students. As the parent/guardian, you should feel comfortable with the training given, so it is important for you to find out what the standards for training are, if any. You might want to attend or participate in the training or seek verification that the training took place.

Source: http://dredf.org/504/intro504.html
Disability Rights Education & Defense Fund

SAMPLE HEALTH CARE PLAN

The attached sample School Health Care Plan was developed by the American Diabetes Association (ADA) and the Disability Rights Education and Defense Fund, Inc. (DREDF). For further information, see the ADA Position Statement, "Care of Children with Diabetes in the School and Day Care Setting." (Diabetes Care, Volume 25, Supplement 1, January 2002).

Health Care Plan for _____

School: _____

Effective Dates:_____

To be completed by parents and the student's health care team. This document should be reviewed with necessary school staff and kept with the student's school records and where easily accessible by staff in emergencies.

Student's Name: _____

Date of Birth: _____

Grade: _____ Homeroom Teacher: _____

CONTACT INFORMATION:

Parent/guardian #1:

Name: _____

Address: _____
_____

Telephone: Home: _____ Work: _____ Cell: _____

Parent/guardian # 2:

Name: _____

Address: _____
_____

Telephone: Home: _____ Work: _____ Cell: _____

Student's Doctor/Health Care Providers:

Doctor:_____

Address: _____

_____

Telephone number: _____

Other Emergency Contacts:

Name: _____

Relationship: _____

Telephone: Home: _____ Work: _____ Cell: _____

Notify parent/guardian or emergency contact in the following situations:

_____

_____

BLOOD GLUCOSE MONITORING

Target range for blood glucose is _____ mg/dl to _____ mg/dl.

Usual times to test blood glucose: _____ _____

_____ _____

Times to do extra blood glucose tests (check all that apply)

_____ Before Exercise
_____ After Exercise
_____ When student exhibits symptoms of hyperglycemia
_____ When student exhibits symptoms of hypoglycemia
_____ Other (explain): _____

_____

Can student perform own blood glucose tests? Yes No

Exceptions: _____

Type of blood glucose meter student uses: _____

Source: http://dredf.org/504/intro504.html
Disability Rights Education & Defense Fund

School personnel trained to monitor blood glucose level and dates of training:

_____

_____

_____

INSULIN

Types, times, and dosages of insulin injections to be given during school:

Time	Type(s)	Dosage
_____	_____	_____
_____	_____	_____
_____	_____	_____

School personnel trained to assist with insulin injection and dates of training:

_____

_____

_____

Can student give own injections? Yes No

Can student determine correct amount of insulin? Yes No

Can student draw correct dose of insulin? Yes No

FOR STUDENTS WITH INSULIN PUMPS

Type of pump: _____ Basal rates: _____

Insulin/carbohydrate ratio: _____ Correction factor: _____

Is student competent regarding pump? Yes No

Can student effectively troubleshoot problems (e.g., ketosis, pump malfunction)? Yes No

Comments: _____

_____

_____

Source: http://dredf.org/504/intro504.html
Disability Rights Education & Defense Fund

MEALS AND SNACKS EATEN AT SCHOOL

The carbohydrate content of the food is important in maintaining a stable blood glucose level.

Meal/Snack	Time	Food content/amount
Breakfast	_____	_____
Mid-morning snack	_____	_____
Lunch	_____	_____
Mid-afternoon snack	_____	_____
Dinner	_____	_____
Snack before exercise?	Yes No	_____
Snack after exercise?	Yes No	_____

Other times to give snacks and content/amount: _____

_____

_____

A source of glucose such as _____ should be readily available at all times.

Preferred snack foods:_____

Foods to avoid, if any: _____

Instructions for when food is provided to the class, e.g., as part of a class party or food sampling: _____

_____

EXERCISE AND SPORTS

A snack such as _____ should be available at the site of exercise or sports.

Restrictions on activity, if any: _____

_____

Student should not exercise if her blood glucose level is below _____ mg/dl or above _____ mg/dl.

Source: http://dredf.org/504/intro504.html
Disability Rights Education & Defense Fund

HYPOGLYCEMIA (Low Blood Sugar)

Usual symptoms of hypoglycemia: _____

_____

_____

Treatment of hypoglycemia: _____

_____

_____

_____

_____

School personnel trained to administer glucagon: _____

_____

Glucagon should be given if the student is unconscious, having a seizure (convulsion), or unable to swallow. If glucagon is required, it should be administered promptly. Then, 911 (or other emergency assistance) and the parents should be called.

HYPERGLYCEMIA (High Blood Sugar)

Usual symptoms of hyperglycemia: _____

_____

_____

Treatment of hyperglycemia: _____

_____

_____

_____

_____

Circumstances when urine ketones should be tested: _____

_____

Treatment for ketones: _____

_____

School personnel trained to test for ketones: _____

_____

Source: http://dredf.org/504/intro504.html
Disability Rights Education & Defense Fund

SUPPLIES AND PERSONNEL

Where are supplies for testing blood glucose levels kept? _____

_____

Where are supplies for administering insulin kept? _____

_____

Where are supplies for testing ketones kept? _____

_____

Where is glucagon kept? _____

_____

Where are supplies of snack foods kept? _____

_____

School personnel trained in the symptoms and treatment of high and low blood sugar and dates of training:

_____

_____

_____

SIGNATURES

This Health Plan has been reviewed by:

_____ _____

Student's Health Care Provider Date

Acknowledged and received by:

_____ _____

Student's Parent(s) or Guardian(s) Date

Acknowledged and received by:

_____ _____

School Representative Date

Source: http://dredf.org/504/intro504.html
Disability Rights Education & Defense Fund

AUTHORIZATION FOR ADMINISTRATION OF SPECIALIZED PHYSICAL HEALTH CARE SERVICES

Student Name: _____Date of Birth: _____

Student Address: _____ City: _____ Zip: _____

Physical/Health condition for which procedure is to be performed _____

_____

Name of treatment or procedure _____

_____

Check one:
_____I have reviewed and approved the attached standardized procedures as written.
_____I have reviewed and approved the attached standardized procedures with my modifications noted.
_____I have attached my recommendations for standardized procedures.

Precautions, possible untoward reactions, and recommended intervention(s)

_____

_____

Time schedule and/or indication for the procedure _____

_____

The above treatment cannot be scheduled before or after school hours. _____

Treatment to be continued as above until _____(date)

Date of Authorization of Treatment _____(date)

Health Care Provider Signature: _____ Telephone: _____

Address: _____

City: _____ Zip: _____

FOR SCHOOL USE ONLY

School nurse's signature: _____ Date: _____

HEALTH PROCEDURES DAILY LOG

Student ________________________________ **Procedure Name** ___________________________

School Name ____ **School Year** _________

Authorized directions for procedure:

____

____

____

____

____

Time Procedure to be done: ____

Date	Procedure Done?		Comments/Notes	Signature
	Yes	No		

Parent/Guardian Request for Specialized Physical Health Care Services

Student Name: _____Date of Birth: _____

I request that the following specialized physical health care service(s) be administered to my child:

_____

_____

_____

(name of procedure)

This procedure(s) is necessary for my child to attend school and cannot be provided before or after school hours

I request that the treatment be administered in accordance with the Authorization for Specialized Physical Health Care. I will notify the school if the health status of my child changes, we change health care providers, or the procedure is changed or cancelled.

I agree to bring the necessary equipment and supplies, properly labeled, with directions for use in school.

The school is authorized to secure emergency medical services for my child whenever the need for such services is deemed necessary by the principal, school nurse, teacher, or other school personnel.

In consideration of this authorization, made at my request, I agree to indemnify and hold harmless the Board of Trustees and school personnel administering the treatment from any claim, liability, or damages caused or claimed as a result of the requested treatment.

I hereby give my permission for exchange of confidential information contained in the record of my child between

_____ and _____

(Licensed Health Care Provider Name) (School Nurse)

_____ _____

(Parent/Guardian Signature) (Date)

_____ _____

(Address) (Home Telephone)

_____ _____

(City/State) (Work Telephone)

Source: Zaiger, D.S. (2000) School Nursing Practice, An Orientation Manual, Chapter IX

EATING AND FEEDING EVALUATION: CHILDREN WITH SPECIAL NEEDS

PART A			
Student's Name		Age	
Name of School	Grade Level	Classroom	
Does the child have a disability? If Yes, describe the major life activities affected by the disability. Does the child have special nutritional or feeding needs? If Yes, complete Part B of this form and have it signed by a licensed physician.		Yes Yes	No No
If the child is not disabled, does the child have special nutritional or feeding needs? If Yes, complete Part B of this form and have it signed by a recognized medical authority.		Yes	No
If the child does not require special meals, the parent can sign at the bottom and return the form to the school food service.			
PART B			
List any dietary restrictions or special diet.			
List any allergies or food intolerances to avoid.			
List foods to be substituted.			
List foods that need the following change in texture. If all foods need to be prepared in this manner, indicate "All." Cut up or chopped into bite size pieces: Finely ground: Pureed:			
List any special equipment or utensils that are needed.			
Indicate any other comments about the child's eating or feeding patterns.			
Parent's Signature		Date:	
Physician or Medical Authority's Signature		Date:	

Source: KDE National School Lunch Administrator's Manual, page 34-35

INFORMATION CARD

Student's Name	Teacher's Name
Special Diet or Dietary Restrictions	
Food Allergies or Intolerances	
Food Substitutions	
Foods Requiring Texture Modifications: Chopped: Finely Ground: Pureed or Blended:	
Other Diet Modifications:	
Feeding Techniques	
Supplemental Feedings	
Physician or Medical Authority: Name Telephone Fax	
Additional Contact: Name Telephone Fax	Additional Contact: Name Telephone Fax
School Food Service Representative/Person Completing Form: Title Signature	Date:

Source: KDE National School Lunch Administrator's Manual, page 34-35

Medical Statement for Children Requiring Special Meals

Name of Student:	School District:
Birth Date:	Grade:
Parent Name:	School Attended:
Telephone:	Telephone:

For Physician's Use

Identify and describe disability or medical condition, including allergies, that requires the student to have a special diet. Describe the major life activities affected by the student's disability (see back of form).

Diet Prescription (check all that apply):

❑ Diabetic (include calorie level, carbohydrate count, and/or attach meal plan): _____

❑ Modified Texture and/or Liquids ❑ Food Allergy (list): _____

❑ Reduced Calorie: _____ ❑ Increased Calorie: _____

❑ Other (describe e.g. PKU, Ketogenic, Tube Feeding): _____

Food Omitted and Substitutions:

Use space to list specific food(s) to be omitted and food(s) that may be substituted. You may attach an additional sheet if necessary. Describe in detail allergies e.g. milk allergy - does that include pudding, cheese, yogurt, etc.

OMITTED FOODS	SUBSTITUTIONS

Indicate Texture (see attached sheet for additional information)**:**

❑ Regular ❑ Chopped ❑ Ground ❑ Pureed

Indicate thickness of liquids:

❑ Regular ❑ Nectar ❑ Honey ❑ Pudding

❑ **Special Feeding Equipment** _____

Additional comments: _____

I certify that the above named student needs special school meals as described above, due to the student's disability or chronic medical condition.

Physician's Signature **Telephone Number** **Date**

Signature of Preparer or Other Contact **Telephone Number** **Date**

I hereby give my permission for the school staff to follow the above stated nutrition plan.

Parent/Guardian **Date**

EPIPEN TRAINING FOR SCHOOL PERSONNEL

Training Guidelines:

School personnel dealing with students who require assistance with EpiPen during the school day shall receive formal training. Training will be provided by personnel such as, but not limited to registered nurses, physicians, pharmacists and/or dentist. Medical personnel should adhere to the practice act standards for their profession as governed by the appropriate licensing authority.

Purpose: to assist student at the time of a life-threatening emergency

Objectives: Upon completion of the EpiPen training, the participant(s) will demonstrate and/or verbalize the following competencies:

1. What authorization forms required to be completed for students with EpiPen under JCPS requirements and under KY law when a student can carry/self-administer own medication
2. Know the five rights (5 R's) of medication administration
3. Read medication label and how to correctly follow directions on medication label
4. Proper storage of prescription medication
5. Have a basic understanding of Anaphylaxis and its signs and symptoms
6. How to appropriately administer and EpiPen
7. Steps to follow after administering EpiPen
8. How to call EMS (9-911)

Evaluation process

Objectives will be evaluated through either post-test or return demonstration(s), post-training monitoring, and annual training

Primary Care Provider Authorization: Epipen (Side One)

Student Name: _____ Date of Birth: _____

School: _____ School Year: _____

Allergy to: _____

Asthma: ☐ Yes ☐ No

Signs of an allergic reaction include:

Systems:	Symptoms:
Mouth	itching and swelling of the lips, tongue, or mouth
Throat *	itching and/or a sense of tightness in the throat, hoarseness, hacking cough
Skin	hives, itchy rash, and/or swelling about the face or extremities
Stomach	nausea, abdominal cramps, vomiting, and/or diarrhea
Lung*	shortness of breath, repetitive coughing, and/or wheezing
Heart *	"thread" pulse, "passing out"

***The severity of symptoms can quickly change. All above symptoms can potentially progress to a life-**
threatening situation!

EpiPen should be: ☐ kept with child ☐ kept in classroom with teacher ☐ kept in front office

Emergency action for an allergic reaction:
1.Administer emergency medication*

Medication: _____

Dose: _____

Route: _____

2.Call EMS (9-911)
3.Call Parent/ guardian or emergency contacts immediately:

_____ _____ _____
Emergency Contact Telephone No. Relationship

4. Call Primary Care Provider _____
Telephone No._____

****Do not hesitate to administer medication or call for emergency assistance (EMS)**

_____ _____
Printed Name of MD, ARNP, or PA Address

_____ _____
_____
Signature of MD, ARNP, or PA Telephone No. Date

***Note to parent/guardian: Signing this form shall release the _____ Public School District and staff from liability of any nature that might result from this plan of action. I hereby give permission for the above information to be verified with the above health care provider.**

_____ _____ _____
Signature of Parent/Guardian Telephone No. Date

Primary Care Provider Authorization: Epipen (Side Two)

Student Name: _____ Date of Birth: _____

School: _____ School Year: _____

Primary Care Provider's Statement of Need

As primary care provider of the above-name student, I do herby acknowledge the necessity of specific emergency health procedures of this patient in the event he/she experiences the following health concern during the school day: (Identify health concern/diagnosis).

_____

This patient's condition is such of a serious nature that there would not be sufficient time to remove him/her from school premises or to await the arrival of medical help. Therefore, prompt treatment should be given by trained school personnel who have been instructed in the use of: (Specify emergency procedure and/or device required).

_____

_____ _____

Printed Name of MD, ARNP, or PA Address

_____ _____ _____

Signature of MD, ARNP, or PA Telephone No. Date

Parent/Legal Guardian's Authorization and Consent

I am fully aware and have been informed by the above named primary care provider that my child's condition is of such a serious nature that, if it occurs, there would not be sufficient time to remove him/her from the school premises or to await the arrival of medical help. I hereby give my authorization and consent to trained school personnel to give prompt treatment, as specified above, to my child.

*Note to parent/guardian: Signing this form shall release _____ Public School District and staff from liability of any nature that might result from this plan of action. I hereby give my permission for the above information to be verified with the above health care provider.

_____ _____ _____

Signature of Parent/Guardian Telephone No. Date

_____ _____ _____

Emergency Contact Telephone No. Relationship

Please complete both sides of this form

_____

_____

_____

EPIPEN RETURN DEMONSTRATION CHECKLIST

Explanation/Return Demonstration	Performs Independently	Performs with minimum verbal clues	Unable to perform
Verbalizes when to administer EpiPen (signs/symptoms of anaphylactic reaction)			
Verbalizes emergency procedure (get EpiPen, call 9-911, initiate CPR by certified staff In necessary)			
Verbalizes & follows five (5) rights			
Checks EpiPen for completion (especially health care provider signature) Authorization with prescription label & compare to prescription label			
Checks to make sure EpiPen has not expired			
Demonstrates how to properly remove EpiPen from container			
Demonstrates how to properly administer with demo EpiPen			
Verbalizes and demonstrates how to dispose of EpiPen properly			
Verbalizes what to do on fieldtrip(s) and how to maintain EpiPen when at school			

Employee Printed Name: _____

Employee Signature: _____

School: _____ Date: _____

School Nurse Stamp/ Signature: _____

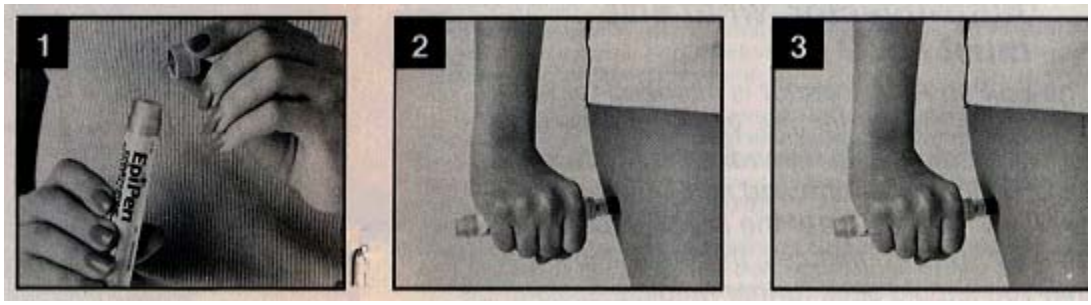
Source: Jefferson County Public Schools Health Services

HOW TO USE EPIPEN ® AND EPIPEN JR. ®

1. Pull of gray activations cap.

2. Hold black tip near outer thigh (always apply to thigh).

3. Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. The EpiPen ®unit should then be removed and discarded. Massage the injection area for 10 seconds.



Source: Jefferson County Public Schools Health Services

ASTHMA TRAINING FOR SCHOOL PERSONNEL

Training Guidelines

School personnel dealing with students who require assistance with inhalers and/or nebulizer treatments during the school day shall receive formal training. Training will be provided by personnel such as, but not limited to registered nurses, physicians, pharmacists and/or dentist. Medical personnel should adhere to the practice act standards for their profession as governed by the appropriate licensing authority.

Purpose: to assist each student with inhaler and/ or nebulizer treatment in order to maintain optimal health and to enhance the educational experience.

Objectives: Upon completion of the Asthma training, the participant(s) will demonstrate and/or verbalize the following competencies:

1. What authorization forms required to be completed for students with Asthma under JCPS requirements and under KY law when a student can carry/self-administer own medication
2. Know the five rights (5 R's) of medication administration
3. Read medication label and how to correctly follow directions on medication label
4. Proper storage of prescription medication and equipment
5. Have a basic understanding of Asthma and its signs and symptoms
6. How to appropriately manage Asthma during the school day
7. What may trigger an Asthma attack
8. How to use an inhaler properly
9. Be familiar with the basic equipment/ supplies used with a nebulizer machine
10. How to safely administer nebulizer treatment
11. Proper documentation of medication administered (inhaler)
12. Proper documentation for nebulizer treatment
13. Proper action to be taken when medication/ procedure not taken/given
14. Use of resources correctly-i.e. nurse, physician, poison control, emergency services when appropriate

Evaluation process

Objectives will be evaluated through either post-test or return demonstration(s), post-training monitoring, and annual training

Primary Care Provider Authorization: Asthma (Side One)

Student: _____ Date of Birth: _____

School: _____ School Year: _____

Triggers (Check all that apply to this child)

☐ Exercise ☐ Animals ☐ Fumes ☐ Carpet

☐ Strong Odors ☐ Pollen ☐ Molds ☐ Respiratory Infection

☐ Chalk Dust ☐ Change in Temperature ☐ Trees/Grass/Shrubbery

☐ Foods (Specify): _____

☐ Other (Specify): _____

Signs and Symptoms student will likely exhibit (Check all that apply)

***Note: Parent/Guardian will be contacted if symptoms persist**

☐ Coughing ☐ Wheezing ☐ Labored/Difficulty Breathing

☐ Other (Specify): _____

Recommended Preventative/Interventive Measures (Check all that apply)

☐ Encourage student to assume position of comfort ☐ Offer warm liquid to drink

☐ Nebulizer **(see back of form)** ☐ Encourage slow, even breaths

☐ Inhaler name and dosage: _____

☐ Other (Specify): _____

Emergency Plan of Action

* If color becomes pale, cyanotic (bluish), or ashen: Call EMS (9-911)
* If breathing stops: CPR certified staff should initiate rescue breathing (and CPR if necessary)
* Contact parent/guardian or emergency contact immediately
* Other (Specify): _____

Inhalers

This student has been trained to use his/her inhaler and should be allowed to carry and use their prescribed inhaler on his/her own. ☐ Yes* ☐ No

***It yes, please note: Student will be expected to carry and use his/her inhaler responsibly.**

Comments: _____

Please complete both sides if this form

Primary Care Provider Authorization: Asthma (Side Two)

Student: _____ Date of Birth: _____

School: _____ School Year: _____

Nebulizer Inhalation Therapy

Medication via the nebulizer will be given at school as follows:
☐ On a daily basis ☐ As needed

Medication No. 1 (Name and Dosage): _____
Medication No. 2 (Name and Dosage): _____
Time of day to administer: _____
Reaction or Side effects: _____
Comments: _____

_____ _____
Printed Name of MD, ARNP, or PA Address

_____ _____ _____
Signature of MD, ARNP, or PA Telephone No. Date

***Note to parent/guardian: Signing this form shall release _____Public School District and staff from liability of any nature that might result from this plan of action. I hereby give permission for the above information to be verified with the above health care provider.**

_____ _____ _____
Signature of Parent/Guardian Telephone No. Date

_____ _____ _____
Emergency Contact Telephone No. Relationship

Please complete both sides of this form

ASTHMA RETURN DEMONSTRATION CHECKLIST

Explanation/Return Demonstration	Performs Independently	Performs with minimum verbal clues
GENERAL GUIDELINES		
Verbalizes & follows five (5) rights		
Verbalizes and/or check's primary care provider (PCP) Asthma authorization for completion (especially PCP's signature) with prescription label		
Verbalizes to or washes hands		
Documents on medication log sheet appropriately		
Verbalizes to call student to office (if appropriate) in allotted time (30 minutes before or 30 minutes after)		
INHALER:		
Checks that canister is firmly positioned in plastic holder and attach spacer if required		
Verbalizes to watch child administer med correctly (shakes inhaler thoroughly, deep breath in & out, on next deep breath take puff, hold breath 5-10 seconds after, and then wait >1 minute before next puff)		
Verbalizes &/or observes student follow above steps with second puff		
Verbalizes &/or places medication back in medication box & locks up medication appropriately		
PEAK FLOW METER:		
Places pointer at base of number scale		
Verbalizes/has student hold meter, take a deep breath, place meter in mouth & close lips around mouth piece, blow out hard & fast		
Verbalizes/has student repeat step two more times		
Verbalizes &/or record highest of 3 readings and follow primary care provides instructions based on reading (i.e. administer medication)		
NEBULIZER		
Verbalizes/shows all equipment and medication to gather		
Verbalizes or sets up nebulizer correctly including placing medication & saline in canister		
Turn on power and observe for mist from mouthpiece or mask		
Verbalizes that student is to place mouthpiece in mouth with tight seal OR place mask over nose & mouth		
Verbalizes &/or observes student for 5-10 minutes until treatment complete		
Verbalizes/show to rinse out and dry nebulizer canister AND put equipment away correctly		
Verbalizes &/or stores and locks up medication appropriately		

Employee Printed Name: _____

Employee Signature: _____

Employee School: _____ Date:_____

School Nurse Stamp/Signature: _____

Source: Jefferson County School Health Services

DIABETES TRAINING FOR SCHOOL PERSONNEL

Training Guidelines:

School personnel dealing with students who require assistance with their Diabetes during the school day shall receive formal training. Training will be provided by personnel such as, but not limited to registered nurses, physicians, pharmacists and/or dentist. Medical personnel should adhere to the practice act standards for their profession as governed by the appropriate licensing authority.

Purpose: to assist each student with their Diabetes in order to maintain optimal health and to enhance the educational experience.

Objectives: Upon completion of the Diabetes training, the participant(s) will demonstrate and/or verbalize the following competencies:

1. What authorization forms are required to be completed for students with Diabetes under JCPS requirements and under KY law when a student can carry/self-administer own medication
2. Have a basic understanding of Diabetes
3. Know signs and symptoms of Hypoglycemia and Hyperglycemia
4. How to appropriately manage Diabetes during the school day based upon Primary Care Providers Diabetes authorization instructions.
5. Be familiar with the basic equipment/ supplies used with glucose monitoring equipment
6. Proper steps to perform/assist with glucose monitoring
7. Proper documentation of glucose monitoring results
8. Importance of establishing a communication system for glucose monitoring results to parent/guardian
9. Proper storage of glucose monitoring equipment/supplies
10. Use of resources correctly-i.e. nurse, physician, poison control, emergency services when appropriate

Evaluation process

Objectives will be evaluated through either post-test or return demonstration(s), post-training monitoring, and annual training

DIABETES BLOOD GLUCOSE TESTING RETURN DEMONSTRATION CHECKLIST

Explanation/Return Demonstration	Performs Independently	Performs with minimum verbal clues	Unable to perform
General Diabetes knowledge			
Check's primary care provider Diabetes authorization for completion (especially primary care provider's signature)			
Verbalizes when glucose monitoring should be performed			
Verbalizes signs/symptoms of hypoglycemia & hyperglycemia			
Verbalizes Universal Precautions			
Blood glucose testing			
Gathers equipment (glucose testing meter, lancet device, strips, record sheet/book, gloves)			
Washes hands & puts on gloves			
Has student wash his/her own hands & dries them			
Inserts lancet into lancing device according to manufacturer's instruction, or observes student inserting lancet appropriately			
Inserts glucose strip into meter according to manufacturer's instructions, or observes student insert testing strip appropriately			
Warms fingers by rubbing, or have student warm fingers			
Puncture side of finger with lancing device, or observe student perform procedure appropriately			
Gently squeeze finger in downward motion to obtain an appropriate size drop of blood or observe student perform appropriately			
Place drop of blood on testing strip, or observe student perform step appropriately			
Apply band aid or have student hold pressure to puncture site briefly			
Verbalizes appropriate steps based on glucose testing results and primary care provider authorization (i.e. nothing needed, give glucose tablets, allow sugar-free drink & bathroom privileges)			
Removes test strip, turns of machine, disposes of lancet and strip appropriately			
Cleans test area			
Remove gloves & wash hands			
Document result on record sheet/book			

Employee Printed Name: _____ Employee Signature: _____

Employee School: _____ Date: _____

School Nurse Stamp/Signature: _____

Source: Jefferson County Public Schools Health Services

DIABETES URINE KETONE TESTING RETURN DEMONSTRATION CHECKLIST

Explanation/Return Demonstration	Performs Independently	Performs with minimum verbal clues	Unable to perform
Urine Ketone Testing			
Check's primary care provider Diabetes authorization for completion (especially primary care provider's signature)			
Verbalizes when ketone testing should be performed			
Verbalizes Universal Precautions			
Gathers equipment (ketone strips, cup for urine, timing device record sheet/book, gloves)			
Washes hands & puts on gloves			
Has student hold ketone strip in urine flow or student urinates in cup then dip ketone strip into urine			
Wait allotted time as directed on ketone test strip bottle			
Compare color of ketone test strip to chart on bottle			
Reads results & follows directions based on primary care provider's diabetes authorization			
Disposes of testing strip & urine appropriately			
Remove gloves & wash hands			
Documents results			

Employee Printed Name: _____ Employee Signature: _____

Employee School: _____ Date: _____

School Nurse Stamp/Signature: _____

Novo Nordisk DIABETES Care

HYPOGLYCEMIA

(Low Blood Sugar)

CAUSES: Too little food, too much insulin or diabetes medicine, or extra exercise.

ONSET: Sudden, may progress to insulin shock.

BLOOD SUGAR: Below 70 mg/dL.
Normal range: 70-115 mg/dL.

SYMPTOMS

SHAKING

FAST HEARTBEAT

SWEATING

ANXIOUS

DIZZINESS

HUNGER

IMPAIRED VISION

WEAKNESS, FATIGUE

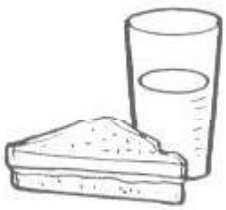
HEADACHE

IRRITABLE

WHAT CAN YOU DO?

Drink a half a cup of orange juice or milk, or eat several hard candies.

TEST BLOOD SUGAR
If symptoms don't stop, call your doctor.



Within 30 minutes after symptoms go away, eat a light snack (half a peanut butter or meat sandwich and a half glass of milk).

Concept developed by Rhoda Rogers, RN, BSN, CDE, Sunrise Community Health Center and Northern Colorado Medical Center

 000-114 1994 Printed in U.S.A.

HYPERGLYCEMIA

(High Blood Sugar)

Nova Nordisk DIABETES Care

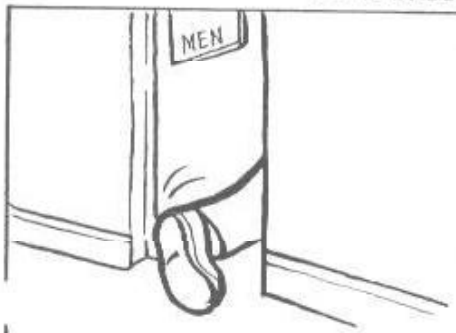
CAUSES: Too much food, too little insulin, illness or stress.

ONSET: Gradual, may progress to diabetic coma.

BLOOD SUGAR: Above 200 mg/dL.
Acceptable range: 115-200 mg/dL.

SYMPTOMS

EXTREME THIRST



FREQUENT URINATION

DRY SKIN

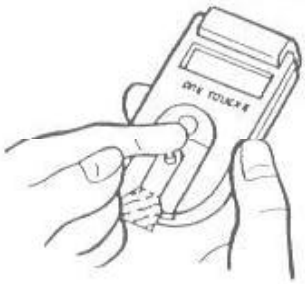
HUNGER

BLURRED VISION

DROWSINESS

NAUSEA

WHAT CAN YOU DO?



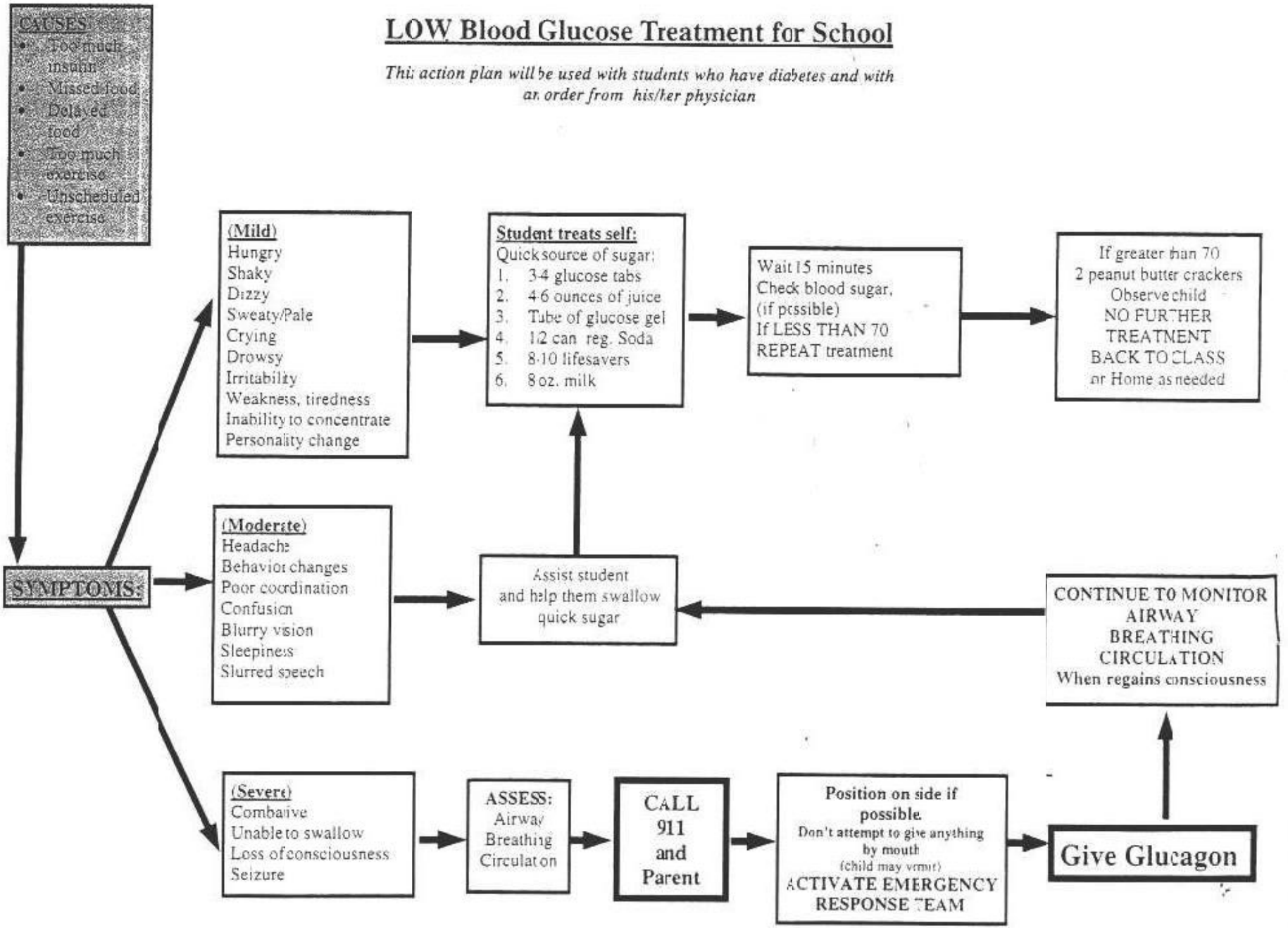
TEST BLOOD SUGAR

If over 250 mg/dL for several tests
CALL YOUR DOCTOR

Concept developed by Rhoda Rogers, RN, BSN, CDE, Sunrise Community Health Center and Northern Colorado Medical Center

000-114 1994 Printed in U.S.A

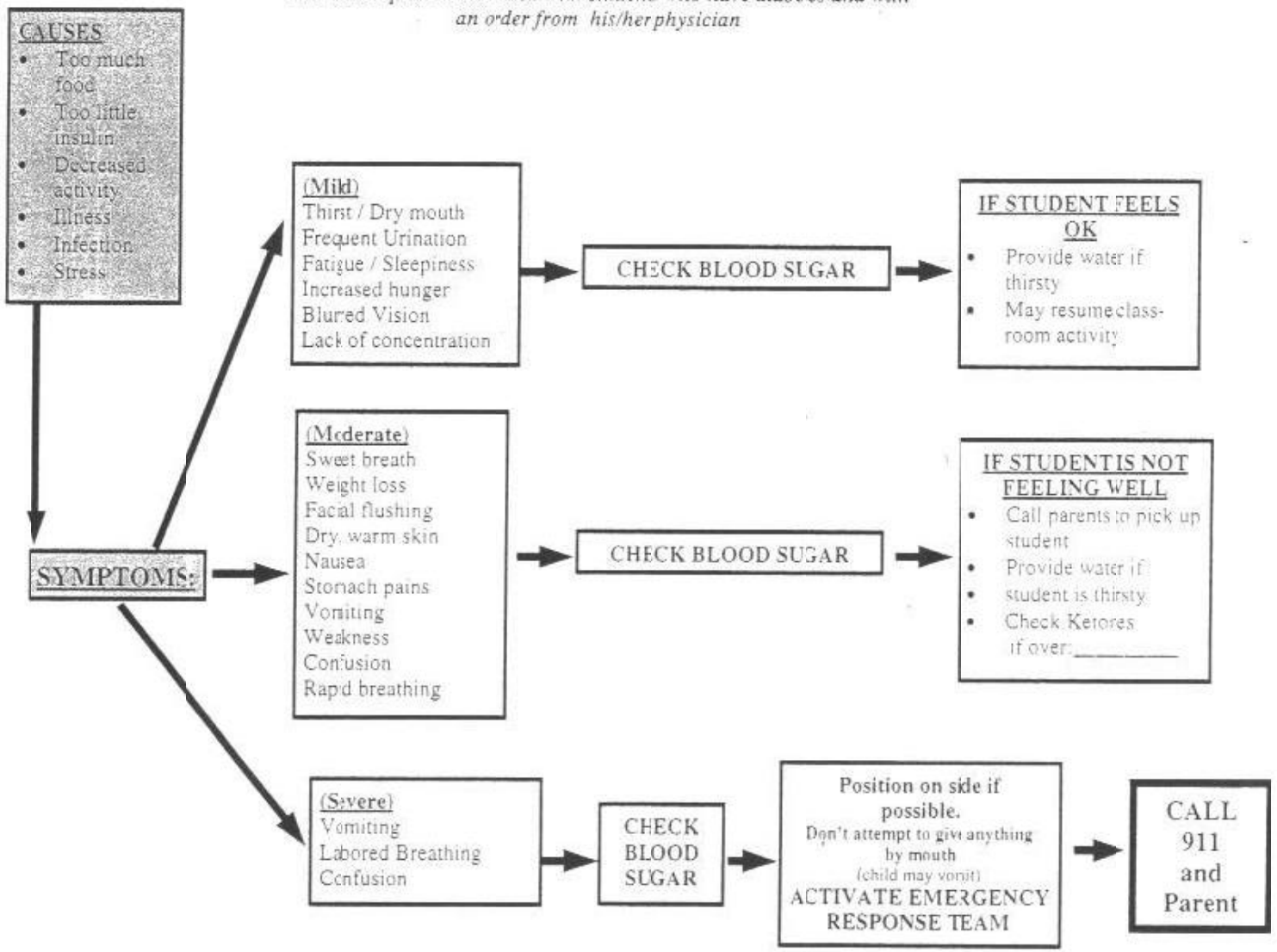
DIABETES EMERGENCY ACTION PLAN



DIABETES EMERGENCY ACTION PLAN

HIGH Blood Glucose Treatment for School

This action plan will be used with students who have diabetes and with an order from his/her physician



SEIZURE AND DIASTAT TRAINING FOR SCHOOL PERSONNEL

Training Guidelines:

School personnel dealing with students who require assistance with Seizure and Diastat during the school day shall receive formal training. Training will be provided by personnel such as, but not limited to registered nurses, physicians, pharmacists and/or dentist. Medical personnel should adhere to the practice act standards for their profession as governed by the appropriate licensing authority.

Purpose: to assist each student at the time of a seizure and when/if Diastat is needed.

Objectives: Upon completion of the Seizure and Diastat training, the participant(s) will demonstrate and/or verbalize the following competencies:

1. What authorization forms are required to be completed for students with Seizure and Diastat under school district requirements
2. Have a basic understanding of seizures and the different types and characteristics of each
3. How to manage seizures during the school day based upon Primary Care Providers seizure authorization.
4. Know the five rights (5 R's) of medication administration
5. Read medication label and how to correctly follow directions on medication label.
6. Proper storage of prescription medication
7. How to appropriately administer Diastat
8. Steps to follow after administering Diastat
9. How to call EMS (9-911)

Evaluation process

Objectives will be evaluated through either post-test or return demonstration(s), post-training monitoring, and annual training

Primary Care Provider Authorization: Seizure Monitoring (Side One)

Student: _____ Date of Birth: _____

School: _____ School Year: _____

Type of Seizure: ☐ Grand Mal (Tonic-clonic) ☐ Petit Mal (Absence)

☐ Other (Specify): _____

Please specify likely characteristics.						Recommended Interventions	Comments
Duration	Specify seconds, minutes, etc.						
Aura	Is there an Aura? ☐ Yes ☐ No Conditions or behaviors that usually precede the seizures:						
Extremities		Limp	Flexed	Extended	Jerking		
	Rt. Arm	☐	☐	☐	☐		
	Lt. Arm	☐	☐	☐	☐		
	Rt. Leg	☐	☐	☐	☐		
	Lt. Leg	☐	☐	☐	☐		
Eyes	Rolled back			☐ Yes	☐ No		
	Staring Straight Ahead			☐ Yes	☐ No		
	Twitching Back and Forth			☐ Yes	☐ No		
	Looking to Right			☐ Yes	☐ No		
	Looking to Left			☐ Yes	☐ No		
Mouth	Drawn to Right			☐ Yes	☐ No		
	Drawn to Left			☐ Yes	☐ No		
	Bites Tongue/Cheek			☐ Yes	☐ No		
	Teeth Clenched			☐ Yes	☐ No		
Breathing	Noisy Breathing			☐ Yes	☐ No		
	Heavy Breathing			☐ Yes	☐ No		
	Shallow Breathing			☐ Yes	☐ No		
Other	Change in skin color			☐ Yes	☐ No		
	Drooling			☐ Yes	☐ No		
	Incontinent-Urine			☐ Yes	☐ No		
	Incontinent-Stool			☐ Yes	☐ No		
	Vomiting			☐ Yes	☐ No		

If symptoms persist after primary care provider recommendations have been followed:

* Notify parent/guardian
* Call EMS (9-911) and refer to Enrollment/Emergency Information Form

If breathing sops:

* Call EMS (9-911) and refer to Enrollment/Emergency Information Form
* CPR certified school personnel should initiate rescue breathing (and CPR if necessary)
* Notify parent/guardian

Please complete both sides of this form

Primary Care Provider Authorization: Seizure Monitoring (Side Two)

Student: _____ Date of Birth: _____

School: _____ School Year: _____

Type of Seizure: ☐ Grand Mal (Tonic-clonic) ☐ Petit Mal (Absence)

☐ Other (Specify): _____

In the event of generalized seizure activity, the following observations and monitoring procedures will be followed by school staff:

* Ease student to the floor (unless harnessed securely in wheelchair and breathing is not restricted).
* Remove hazards in the area, such as, sharp or hard objects, to prevent further injury.
* Loosen tight clothing at the neck.
* Turn student onto his/her side to allow saliva to drain and to keep airway open.
* Cushion the student's head with something soft.
* Monitor student while the seizure runs its course and speak to him/her in calming tones.
* Following the seizure, allow the student to rest as needed in a quiet supervised area.
* Following each occurrence, report activity to parent/guardian in writing and by telephone.

Signals of an emergency situation:

* If any seizure last longer than five (5) minutes, or
* If there is any continued, progressive respiratory distress, or
* If another seizure starts right after the first, then do the following:

Emergency action:

* Call EMS (9-911) and refer to Enrollment/Emergency Information Form.
* If breathing stops, CPR certified school personnel should initiate rescue breathing (and CPR started if needed) while awaiting medical assistance.
* Notify parent/guardian

Primary Care Provider' comments (i.e. medication, other measure- attach additional sheet if necessary):

_____

_____

_____

_____ _____

Printed MD, ARNP, or PA Address

_____ _____ _____

Signature of MD, ARNP, or PA Telephone No. Date

*** Note to parent/guardian: Signing this form shall release the _____Public School District and staff from liability of any nature that might result from this plan of action. I hereby give permission for the above information to be verified with the above health care provider.**

_____ _____ _____

Signature of Parent/Guardian Telephone No. Date

_____ _____ _____

Emergency Contact Telephone No. Relationship

Please complete both sides of this form

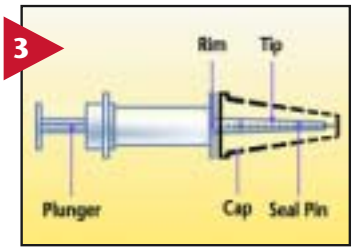
How to Administer

Diastat® (diazepam rectal gel)

Stop the seizure. Fast.

Put person on their side where they can't fall

Get medicine



Get syringe

Push up with thumb and pull to remove protective cover from syringe

Lubricate rectal tip with lubricating jelly

Turn person on side facing you

Bend upper leg forward to expose rectum

Separate buttocks to expose rectum

Gently insert syringe tip into rectum

Note: Rim should be snug against rectal opening.

SLOWLY COUNT OUT LOUD TO THREE...1...2...3

Slowly count to 3 while gently pushing plunger in until it stops

Slowly count to 3 before removing syringe from rectum

Slowly count to 3 while holding buttocks together to prevent leakage

ONCE DIASTAT® IS GIVEN

Keep person on side facing you, note time given and continue to observe

CALL FOR HELP IF ANY OF THE FOLLOWING OCCUR

- Seizure(s) continues 15 minutes after giving DIASTAT or per the doctor's instructions: _____
- Seizure behavior is different from other episodes.
- You are alarmed by the frequency or severity of the seizure(s).
- You are alarmed by the color or breathing of the person.
- The person is having unusual or serious problems.

Local Emergency Number: _____

(please be sure to note if your area has 911)

Doctor's Number: _____

Information for Emergency Squad: *Time DIASTAT given:* _____ *Dose:* _____

DIASTAT RETURN DEMONSTRATION CHECKLIST

Explanation/Return Demonstration	Performs Independently
Verbalizes when to administer Diastat	
Verbalizes steps to secure student's safety during a seizure	
Verbalizes emergency procedure (get Diastat, call 9-911, initiate CPR by certified staff In necessary)	
Verbalizes & follows five (5) rights	
Checks Seizure Primary Care Authorization form for completion (especially health care provider signature) & compare to prescription label	
Checks to make sure Diastat has not expired	
Verbalizes/demonstrates how to properly position student for Diastat administration	
Demonstrates how to properly administer with demo Diastat	
Verbalizes and demonstrates how to dispose of Diastat syringe properly	
Verbalizes what to do on fieldtrip(s) and how to maintain Diastat when at school	

Employee Printed Name: _____

Employee Signature: _____

School: _____ Date: _____

School Nurse Stamp/ Signature: _____

Source: Jefferson County Public Schools Health Services

Primary Care Provider Authorization: Catheterization

Student: _____ Date of Birth: _____

School: _____ School Year: _____

Times(s) for procedure: _____

Recommended position: _____

_____

Health Care provider's comments: _____

	Primary Care Provider: Describe typical characteristics	Parent/Guardian: Describe typical characteristics
Urine *Clear/Cloudy *Color/Blood *Odor *Amount		
Student *Temperature *Comfort *Fluid intake		

Other health care provider's comments: _____

_____

***Please note: When any changes in the student's typical characteristics (listed above) are observed, the parent/guardian must be notified immediately.**

****Latex Allergy:** ☐ Yes ☐ No

_____ _____

Printed MD, ARNP, or PA Address

_____ _____ _____

Signature of MD, ARNP, or PA Telephone No. Date

*** Note to parent/guardian: Signing this form shall release the _____Public School District and staff from liability of any nature that might result from this plan of action. I hereby give permission for the above information to be verified with the above health care provider.**

_____ _____ _____

Signature of Parent/Guardian Telephone No. Date

_____ _____ _____

Emergency Contact Telephone No. Relationship

SPECIAL HEALTH CARE SERVICES TRAINING FORM

Student _____ Birth Date_____ Social Security_____

School/Class_____ School Personnel Trained to Perform Procedure_____

Consider this a prescription for the above named student's **Intermittent Straight Catheterization: Female**

Perform the procedure as outlined in this checklist.

M.D._____

Dates of Training/Monitoring (T=Training, M=Monitoring)

Date														
Information & Procedure Steps														
Equipment														
Catheter (size_____)														
Basin or container for urine collection														
Good lighting														
Water soluble lubricant														
Soap & warn water—towels														
Procedure														
Wash the hands thoroughly														
Assemble the equipment within easy reach														
Separate the labia to wash the genitalia with soap and water; use downward strokes from front to back; rinse and dry.														
Lie or sit down with the knees flexed, or stand with one foot on the edge of the commode; place a towel or a waterproof pad underneath the buttocks if the patient is lying or sitting down.														
Use identify the labia, clitoris, urethral meatus, and vagina														
Lubricate the tip of the catheter														
With your nondominant hand, hold the labia apart with your index and ring finger														
With your donimant hand, insert the tip of the catheter into the urethral meatus, until urine flows (approximately 2 to 3 inches)														

Source: Madison County Health Department

Date														
Release the labia, with your dominant hand, gently and slowly withdraw the catheter, keeping the tip held up to prevent the dribbling of urine														
Dispose of the urine														
Clean the catheters with soap and water then boil them for 20 minutes. Air dry the catheters in a plastic bag for future use														
Replace torn, hardened, or cracked catheters														
Clean and replace your equipment. Discard disposable items in a plastic trash bag, and secure														
Considerations														
Intermittent self-catheterization should be done at least 4 times a day and at bedtime.														
Instruct the patient/caregiver that to prevent infections the bladder should not hold more than 11/2 cups of urine at a time.														
Documentation Guidelines														
Document on the Special Health Care Services Record (MCHD 123)														
The procedure and patient toleration														
Color, odor, amount, and characteristics of the patient's urine														
Catheter size														
Urine collected for laboratory analysis and designated laboratory for delivery as appropriate														
Other pertinent findings														
Code each step "+" or "-"														

Signs and Symptoms of Problems: Fever, Strong smelling urine, abdominal pain, (Other)_____

_____ _____ _____

Instructor Date Date

_____ _____

Parent Signature Date

Source: Madison County Health Department

G-TUBE FEEDING AND/OR G-TUBE MEDICATION ADMINISTRATION TRAINING FOR SCHOOL PERSONNEL

Training Guidelines:

School personnel dealing with students who require g-tube feeding and/or g-tube medication administration during the school day shall receive formal training. Training will be provided by personnel such as, but not limited to registered nurses, physicians, pharmacists and/or dentist. Medical personnel should adhere to the practice act standards for their profession as governed by the appropriate licensing authority.

Purpose: to provide student with g-tube feeding and/or g-tube medication administration in order to maintain optimal health and to enhance the educational experience.

Objectives: Upon completion of the g-tube feeding and/or g-tube medication administration training, the participant(s) will demonstrate and/or verbalize the following competencies:

1. What authorization form(s) is required to be completed for students with g-tube feeding and/or g-tube medication administration under JCPS requirements
2. Know the five rights (5 R's) of medication administration
3. Read medication label and how to correctly follow directions on medication label
4. Proper storage of prescription medication and equipment
5. Have a basic understanding of what a g-tube is, the purpose, and the different types of g-tubes
6. How to appropriately manage a g-tube during the school day based upon the Primary Care Providers G-tube authorization and Medication Authorization
7. Be familiar with the basic equipment/ supplies needed for g-tube feeding and g-tube medication administration
8. How to safely administer g-tube feeding and g-tube medication
9. Proper documentation of g-tube feeding
10. Proper documentation for g-tube medication administration
11. Proper action to be taken when g-tube feeding not able to be administered
12. Proper action to be taken when g-tube medication is not administered
13. What to do if g-tube comes out
14. Use of resources correctly-i.e. nurse, physician, poison control, emergency services when appropriate

Evaluation process

Objectives will be evaluated through either post-test or return demonstration(s), post-training monitoring, and annual training

Primary Care Provider Authorization: G-Tube Feeding

Student: _____ Date of Birth: _____

School: _____ School Year: _____

Type of G-tube	**Pump to be used:**
☐ Button	☐ Yes
☐ Catheter	☐ No
☐ Other (Specify):	☐ Flow rate _____cc/hour

Name of formula: _____

Type of Pump: _____

Gravity: ☐ Yes ☐ No

Volume to be given: _____cc over _____ minutes

Volume of water to follow feeding: _____ cc

Feeding time(s): _____ _____ _____ _____

Positions: During feeding: _____
After feeding: _____

Note to Health Care Provider/Parent/Guardian:

- The parent/guardian will be notified if a tube becomes **clogged or dislodged.**
- School personnel cannot forcefully flush or replace a tube into the stomach.
- Feeding formula must be sent to school in the **original unopened container**.

Additional health care provider's comments: _____
_____

_____ _____
Printed Name of MD, ARNP, or PA Address

_____ _____ _____
Signature MD, ARNP or PA Telephone No. Date

*Note to parent/guardian: Signing this form shall release the Jefferson County Public School District and staff from liability of any nature that might result from this plan of action. I hereby give permission for the above information to be verified with the above health care provider.

_____ _____ _____
Signature of Parent/Guardian Telephone No. Date

_____ _____ _____
Emergency Contact Relationship Telephone No.

G-TUBE FEEDING RETURN DEMONSTRATION CHECKLIST

Explanation/Return Demonstration	Performs Independently	Performs with minimum verbal clues	Unable to perform
Bolus/Gravity			
Check's G-tube authorization for completion (especially MD signature)			
Gathers equipment (feeding, syringe or gravity bag, water (if prescribed), gloves)			
Washes hands & puts on gloves			
Positions student comfortably as prescribed on authorization			
Remove g-tube cap and insert syringe, unclamp tubing (if applicable), pour feeding into syringe and allow to flow, or if button- insert extension tube, turn to lock into place, insert syringe, unclamp, & pour feeding into syringe allow to flow			
Continue to pour feeding into syringe until feeding completed			
Raise or lower syringe to adjust flow as needed			
When feeding complete, pour in prescribed amount of water (if applicable)			
Clamp tubing, remove syringe, & reclamp g-tube, if button clamp extension, turn to unlock, remove syringe and extension, replace clamp			
Make sure g-tube is tucked into clothing			
Remove gloves & wash hands			
Wash out syringe, allow to dry, & put with other equipment for next feeding			
Documents feeding preformed & tolerated			
Continuous/Pump			
Check's G-tube authorization for completion (especially MD signature)			
Gathers equipment (feeding, gravity bag, pump, water (if prescribed), gloves)			
Washes hands & puts on gloves			
Positions student comfortably as prescribed on authorization			
Pour feeding into gravity bag, prime pump as directed (if applicable) remove g-tube cap, & insert tubing end into g-tube, set flow rate, unclamp tubing and turn pump to run, or if button- connect feeding bag end into extension tube & prime if appropriate, turn to lock extension into place, unclamp tubing, turn pump to run			
When feeding complete, pour in prescribed amount of water (if applicable)			
Clamp tubing, turn off pump, disconnect, & reclamp g-tube, if button- clamp extension, turn off pump, turn to unlock, remove extension, replace clamp			
Make sure g-tube is tucked into clothing			
Remove gloves & wash hands			
Documents feeding preformed & tolerated			

Employee Printed Name: _____ Employee Signature: _____

Employee School: _____ Date: _____

School Nurse Stamp/Signature: _____

Source: Jefferson County Public Schools Health Services

Primary Care Provider: Ostomy Care

Student: _____ Date of Birth: _____

School: _____ School: _____

Diagnosis: _____

Type of ostomy: ☐ Colostomy ☐ Iliostomy ☐ Urostomy

Brand name of appliance: _____

Primary Care Provider: please specify all guidelines required for student during school day below
(Please provide step-by-step procedure on ostomy skin care, etc.):

1. _____
   _____
2. _____
   _____
3. _____
   _____
4. _____
   _____
5. _____
   _____

Other health care provider's comments: _____

_____

_____ _____
Printed Name of MD, ARNP, or PA Address

_____ _____ _____
Signature of MD, ARNP, or PA Telephone No. Date

*** Note to parent/guardian: Signing this form shall release the _____ School District and staff from liability of any nature that might result from this plan of action. I hereby give permission for the above information to be verified with the above health care provider.**

_____ _____ _____
Signature of Parent/Guardian Telephone No. Date

_____ _____ _____
Emergency Contact Telephone No. Relationship

TRAINING FOR DESIGNATED STAFF

Student _____ Birth Date_____ Social Security_____

School/Class_____ School Personnel Trained to Perform Procedure_____

Consider this a prescription for the above named student's **Changing COLOSTOMY/ILEOSTOMY**

Perform the procedure as outlined in this checklist. COLLECTION BAG M.D._____

Dates of Training/Monitoring (T=Training, M=Monitoring)														
Date														
Information & Procedure Steps														
Equipment														
Assemble the equipment within easy reach														
Soap and water, soft cloth or gauze														
Skin preparation, Adhesive tape														
Clean bag and belt, if needed														
gloves, scissors (if needed to cut skin barrier)														
Procedure														
Wash the hands thoroughly and apply gloves.														
Provide private area and assist student to undress to extent needed for procedure														
Empty contents of used bag into toilet.														
Carefully remove the used bag and skin barrier by pushing the skin away from the bag, instead of pulling the bag off the skin.														
If a skin barrier is used that requires fitting, measure stoma.														
Clean stoma.														
Inspect the skin and state reasons you would notify the school nurse or parent.														
Apply skin barrier to skin around stoma														
Remove backing from adhesive and place over the stoma.														
Remove gloves and wash hands														
Record procedure on flow sheet														
Report to parent by the end of day any change in stool pattern														
Staff will report the following problems:														
Collection bag requires frequent changes.														

Dates of Training/Monitoring (T=Training, M=Monitoring)														
Date														
Any change in stool pattern.														
Red irritated skin around stoma.														
Drops of blood: pat gently with soft cloth gauze.														
Moderate bleeding: apply gently pressure using soft cloth / gauze.														
Heavy / continued bleeding: apply firm pressure using soft gauze. Delegate call to EMS / 911.														

_____ _____

Instructor Date

_____ _____

Parent Signature Date

DELEGATION OF HEALTH SERVICE(S) TO SCHOOL PERSONNEL

School Year: _____ Date: _____

Employee Printed Name_____

School: _____

I have been instructed on my school district's guidelines for:

Employee Initials	Health Services Nurse's Initials	
		Administration of medications on daily basis and field trips
		Administration of medication on field trips only
		Asthma and Mini-nebulizer treatments
		Diabetes and blood glucose monitoring
		Epi-pen
		G-tube feedings
		G-tube medication administration
		Seizure and diastat
		Trachs and suctioning

I understand that I am to follow district guidelines as delegated by the School Nurse. Upon signing this, I consent to perform the health service(s) initialed above by the delegating School Nurse and myself, possess the training and skills, and have demonstrated competency to safely and effectively perform the health service(s).

_____ _____

Employee Signature Date

I have provided training to this individual on the health service(s) initialed above by the employee and myself in accordance with school district guidelines. She/he has demonstrated knowledge and understanding of this/these health service(s).

_____ _____

School Nurse Stamp/Signature Date

Adapted from: Jefferson County Public School Health Services

Primary Care Provider Authorization: Tracheostomy Suctioning/Replacement

Student: _____ Date of Birth: _____

School : _____ School Year: _____

Diagnosis: _____

Type and Size of trachea tube: _____

Suctioning frequency (Check one and fill in):

☐ Every _____ minutes ☐ Every _____ hours

☐ As needed based upon signs and symptoms as follows:

- ☐ Choking ☐ Continuous coughing
- ☐ Gurgling ☐ Upon student's request
- ☐ Other (Specify): _____

In the event the trach tube becomes dislodged during the school day, may trained school personnel replace it? ☐ Yes ☐ No

**** Latex Allergy:** ☐ Yes ☐ No

Suctioning instructions:

☐ Saline installation needed

☐ Depth to insert catheter: _____

☐ Other (Explain): _____

Additional health care provider's comments/instructions: _____

_____

_____ _____

Printed Name of MD, ARNP, or PA Address

_____ _____ _____

Signature of MD, ARNP, or PA Telephone No. Date

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_____ _____ _____

Signature of Parent/Guardian Telephone No. Date

_____ _____ _____

Emergency Contact Telephone No. Relationship

TRACHEOTOMY SUCTIONING / REPLACEMENT RETURN DEMONSTRATION CHECKLIST

Explanation/Return Demonstration	Performs Independently	Performs with minimum verbal clues	Unable to perform
Tracheotomy Suctioning			
Check's tracheotomy suctioning/replacement authorization for completion (especially primary care provider's signature)			
Gathers equipment (suction machine, suction catheter, saline (if applicable), gloves)			
Positions student comfortably as prescribed on authorization			
Opens suction catheter kit, attach end of suction catheter to suction machine			
Washes hands & puts on gloves			
Turns on suction machine, test suction equipment with glass of water, if working properly proceeds with suctioning student's tracheotomy			
(*) Inserts suction catheter into tracheotomy prescribed depth			
(*) Applies suction and removes suction catheter while rolling suction catheter in fingers			
Rinses suction catheter by inserting into glass of water			
Waits a few minutes to see if suction needs to be repeated			
If necessary repeats above steps for suctioning (*)			
Rinses suction catheter by inserting into glass of water			
Remove gloves & wash hands			
Documents feeding preformed & tolerated			
Tracheotomy replacement			
Check's tracheotomy suctioning/replacement authorization for completion (especially if tracheotomy tube may be replaced and primary care provider's signature)			
Gathers extra tracheotomy tube and open			
Washes hands and puts on gloves			
Inserts new tracheotomy tube			
Call 9-911 and parent/guardian			
Document procedure done			

Employee Printed Name: _____ Employee Signature: _____

Employee School: _____ Date: _____

School Nurse Stamp/Signature: _____

Adapted from: Jefferson County Public School Health Services

Primary Care Provider Authorization: Ventilator

Student Name: _____ Date of Birth: _____

School: _____ School Year: _____

Diagnosis: _____

Equipment Company: _____

Type of Ventilator: _____

Ventilator Settings: _____

Specific primary care provider's instructions for ventilator (i.e., signs and symptoms to look for when taking nap/sleeping, etc.): _____

_____

Student needs nurse (Check all that is appropriate):

☐ Transportation/Bus ☐ In Classroom ☐ On Fieldtrip

☐ Available on school premises/in building for emergency assistance

Additional health care provider's comments: _____

_____

_____ _____

Printed Name of MD, ARNP, or PA Address

_____ _____ _____

Signature of MD, ARNP or PA Telephone No. Date

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_____ _____ _____

Signature of Parent/Guardian Telephone No. Date

Source: Jefferson County Public Schools Health Services